HHS had taken broad steps in FY 2001 to mobilize efforts to increase health care quality—particularly with respect to the elderly—and to augment support systems for patient and consumer safety. Research on quality of care also resulted in findings that when implemented, can help the outcomes and costs of patient care.

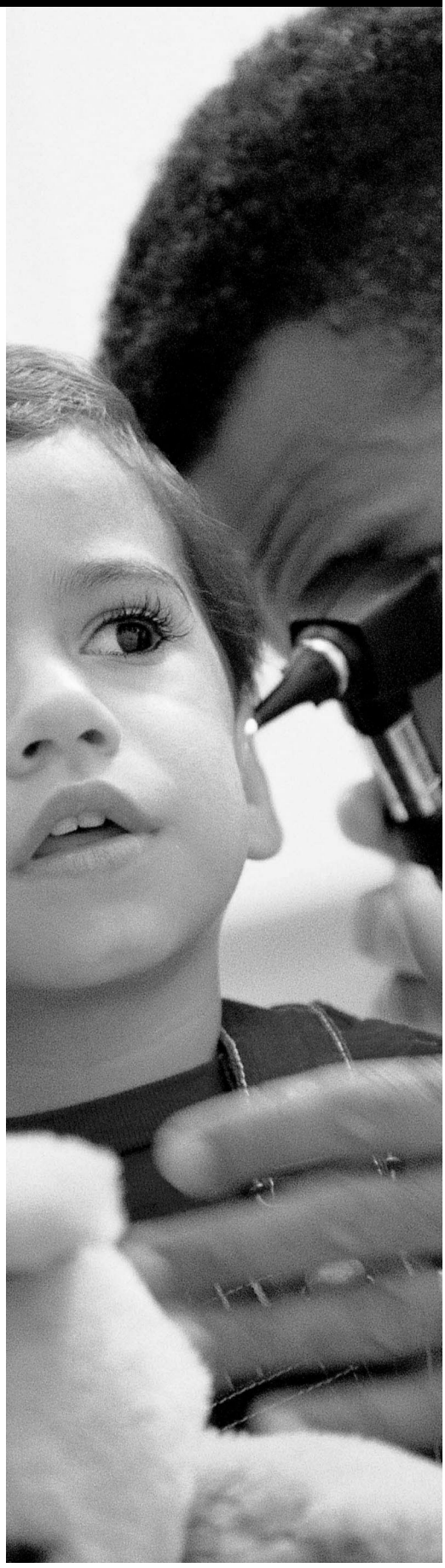
Patient Safety, Rights, and Privacy

HHS continued its effort to improve patient safety, rights, and privacy this year.

In November 1999, The Institute of Medicine reported that as many as 44,000 to 98,000 people die in hospitals each year as a result of medical errors. It is estimated that about 7,000 people die each year from medication errors alone.

On April 23, 2001, HHS formally established a new Patient Safety Task Force, led by the Agency for Healthcare Research and Quality (AHRQ), Center for Disease Control and Prevention (CDC), Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS). The purpose of the task force is to identify and collect data that will be useful for healthcare providers, states, and other health agencies. The task force met to discuss the collection and use of patient safety data. Representatives of medical professional organizations, state health departments, state licensure boards, accrediting bodies, patient advocacy groups and others participated. The task force will study how to implement a user-friendly, internet-based format for reporting on patient safety to enable faster cross-matching and electronic analysis of data and more rapid responses to patient safety problems.

Overall, in FY 2001, AHRQ invested $50 million in 90 new research grants, contracts, and other projects to reduce medical errors and improve patient safety. The results of this effort will identify improvement strategies for reporting medical errors data, using information technology to prevent errors, understanding the impact of working conditions on patient safety, developing innovations, and disseminating research results. The performance target in FY 2001 was to fund a minimum of 40 projects in reducing medical errors and enhancing patient safety, therefore, AHRQ exceeded its target.



On April 12, 2001, Secretary Thompson announced that HHS would immediately begin the process of implementing the patient privacy rule that gives patients greater access to their own medical records.

Also in FY 2001, new regulations were published to give Medicaid beneficiaries in managed care plans the same types of protection that participants in managed care plans would receive under patient rights' legislation that was proposed in Congress. This would include emergency room care whenever and wherever the need arises, access to a second opinion, and grievance systems, among other rights.

Under Medicare, the appeal process is a critical safeguard already available to all Medicare beneficiaries to ensure their rights. This appeal process allows beneficiaries to challenge denials of payment or service. On April 27, 2001, CMS released a policy letter that requires Medicare+Choice organizations to report to CMS on their internal aggregate level appeal data. CMS will analyze this information to understand more about the number and type of appeals filed by beneficiaries and the disposition of the appeals. This letter satisfies part of the FY 2001 target. The other part of the target, collection of appeal data, has been delayed due to concerns regarding burdening Medicare+Choice organizations with increased reporting requirements. This same concern delayed implementation in FY 2000. Therefore, that part of the target was not met. Further evaluative efforts will be undertaken to determine data needs necessary to comply with the Benefits Improvement and Protection Act, and the extent to which new, additional data elements should be collected in order to improve the administration of this essential beneficiary protection.

In addition to safety and other protections, citizens have the right to keep their medical records confidential. On April 12, 2001, Secretary Thompson announced that HHS would immediately begin the process of implementing the patient privacy rule that gives patients greater access to their own medical records and more control over how their personal information is used. The Secretary indicated he will issue modifications and guidance as necessary to correct unintended effects of the rule on access to or the quality of health care. Then on July 6th, HHS issued the first in a series of guidance material on new federal privacy protections for medical records and other personal health information.

Heart Attack Survival Rates

Adverse health conditions clearly affect a large number of Medicare beneficiaries, and heart disease is the most common condition for which Medicare beneficiaries are hospitalized.

Improving treatment for heart attacks has been a focus of CMS' Health Care Quality Improvement Program since its inception in 1992. CMS works through a network of health care providers to reduce deaths from heart attacks by improving hospital performance, using such techniques as aspirin administered to prevent blood clots, beta blockers to decrease the heart's workload and oxygen need, and counseling to assist patients in eliminating smoking. This nation-wide effort focused on implementing known successful interventions for properly treating heart attacks and preventing second heart attacks.

Program performance for improved heart attack survival rates is measured by the one-year mortality rate for Medicare beneficiaries following hospital admission for heart attack. The target periods cover two years. In FY 1995-1996, the baseline was a 31.2 percent mortality rate. This rate increased for the FY 1997-1998 and FY 1998-1999 target periods (31.7 and 32.3 percent, respectively). This may be attributable to several factors including that our efforts in this area have been phased in gradually; there may have been a change in diseases that exist or occur concurrently; and the age distribution of the Medicare population has increased, which could require risk adjustment. Analyses are underway to try to determine the effect of these factors and to modify the goal accordingly. The FY 2000-2001 target was 27.4 percent; actual performance data will be available in FY 2003.

A national intervention program, similar to the pilot project, was initiated in FY 2000. It is expected that this will result in a decline in one-year mortality after heart attacks by about one percentage point once interventions are widely adopted.

Medicaid Outcomes at Health Centers versus Other Sources of Health Care

Health Centers for the underserved and uninsured provide a high quality of primary health care that reduces

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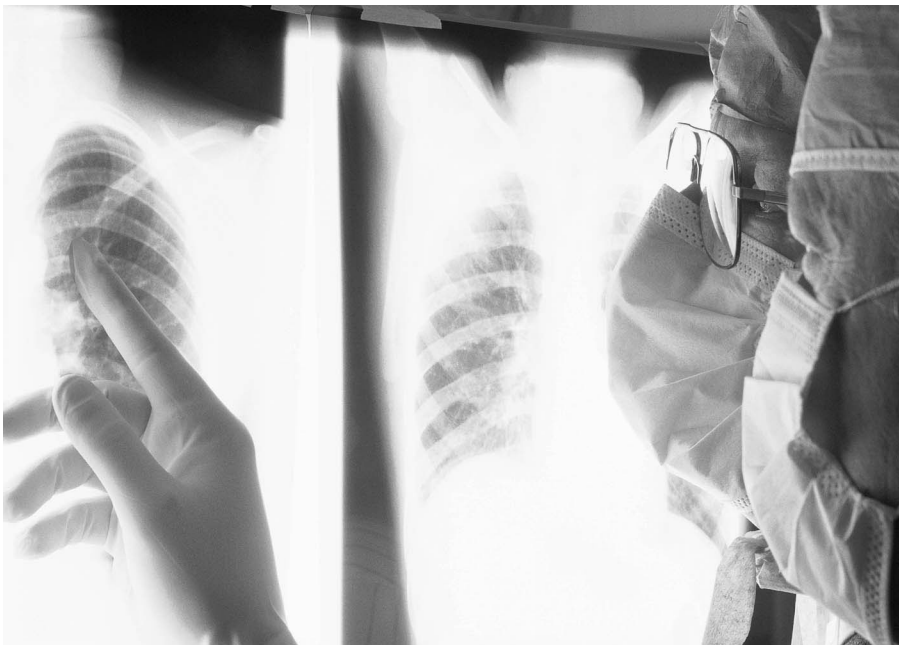
hospitalizations and emergency room use, reduces annual Medicaid costs, and helps prevent more expensive chronic disease and disability. Having a regular source of primary health care has been shown to have as much of an effect on health status disparities as income inequality. This bodes well for eventual reduction and elimination of their health status disparities. This is evidenced by the facts that: 1) Health Center Medicaid patients are 22 percent less likely to be inappropriately hospitalized than Medicaid beneficiaries who obtain care elsewhere, and 2) while patients at Health Centers have rates of hypertension and diabetes that far exceed national prevalence rates for comparable racial/ethnic and socioeconomic groups, Health Center patients who are diabetics are twice as likely to have their glycohemoglobin tests performed at regular intervals than national norms, and hypertensives are more than three times as likely to report that their blood pressure is under control.

The performance targets for FY 2001 are that 90 percent of Health Center diabetics have up to date glycohemoglobin testing and 96 percent of Health Center hypertensives report that their blood pressure is under control. Actual performance data will be available in late 2002 and 2003, respectively. According to the latest actual data, a 60 percent glycohemoglobin test rate was achieved in FY 1999, which met the target for that year. Also the reported hypertension control rate was 90 percent in FY 1995. The FY 2001 target for decreasing the proportion of Health Center users who are hospitalized for potentially avoidable conditions is 13 per 1000. According to the most recent data, that rate was 14.7 per 1000 in FY 1997.

Tracking individual Health Center performance on all these measures will enable the program to continuously improve its overall level of performance. Successful strategies employed in Health Centers with rates that far exceed the average can be shared with Centers that could use improvement in their rates.

Long-Term Care and Nursing Homes

Individuals in long term care facilities, or nursing homes, are a particularly vulnerable population, and consequently, it is an area of considerable importance. Achieving low prevalence of physical restraint use is an accepted indicator of quality of care, and considered a proxy for measuring the quality of life for nursing home residents. The use of restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. CMS seeks to protect beneficiaries by surveying facilities participating in the Medicare program. This is accomplished by the State Survey and Certification Program, which has been successful. The most recent FY 2000 data shows that the target to decrease use of restraints in nursing homes to 10 percent was met. The target for FY 2001 is also no more than 10 percent and final data is expected in March 2002. Other improvements were made to the survey and certification program in FY 2001 to ensure that states conduct surveys on a timely basis. The CMS used a new price-based methodology for state budgets that reflected whether states met the average national survey time for long term care facilities.



Health Centers for the underserved and uninsured provide a high quality of primary health care that reduces hospitalizations and emergency room use, and reduces annual Medicaid costs.

Assisted living facilities are often viewed as providing an alternative to nursing home care. This past year, the first national study of assisted living facilities for elderly individuals was released. "A National Study of Assisted Living for the Frail Elderly" was published in August 2001. It has been underway since 1994 and profiles the residents, staff, walk-through observations, and the facilities. Among the major findings was that most residents surveyed feel that they are treated with respect, affection and dignity by facility staff, however, they were concerned over the number of staff available and staff turnover. This report will be useful for the elderly and their caregivers in assessing long term care options.

Also, in February 2001 the HHS National Family Caregiver Support Program was launched to help family members provide care for the elderly at home. As the largest new support program under the Older Americans Act since 1972, states received $113 million in grants to run programs that provide critical support, including home and community-based services, to help families maintain their caregiver roles.

New Freedom Initiative

On February 1, 2001 President Bush announced the New Freedom Initiative to help remove barriers that can prevent the 54 million Americans living with disabilities from participating fully in community life. As part of this effort, Secretary Thompson is heading the Interagency Council on Community Living, a special task force supported by HHS, the Departments of Education, Justice, Labor, Housing and Urban Development, and the Social Security Administration. The Council is charged with evaluating the programs, statutes, and regulations of their respective agencies to determine whether they should be revised or modified to improve the availability of community-based services for qualified individuals with disabilities. In February, HHS began awarding grants under a new $50 million grant program for improving the home and community-based services available to children and adults with disabilities.